

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16392											
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>506 Laurel St.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>506 Laurel St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Claude</u>			First Middle Last <u>Davis</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1918</u>		9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mill</u>				11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Davis</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>230-14-8389</u>				17. INFORMANT <u>Cleveland Davis</u> <u>171 1/2 Fulton St. Brooklyn, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Probable congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>arteriosclerotic heart disease</u> (b) <u>3 days</u> (c) <u>years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>David Rafat</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11-20-66</u>			
EXAMINER'S NAME (Type) <u>DAVID RAFAT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-26-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tindley's Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>					
23. FUNERAL DIRECTOR <u>Samuel Lang</u>				ADDRESS <u>New Church, Va.</u>				24a. REC'D BY REGISTRAR <u>Nov 28 1966</u>			

1-303

Worcester

Peconic City

306 Laurel St

Glade

Male Negro

Laborer

Arthur Davis

No

MA

Peconic City

306 Laurel St

Davis

x July 4, 1918 #8

Ya

Blackman

330 42nd Street New York

USA

Worcester

Print 11-20-66 Thelma Cheryl Ann Peconic City

New York

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME
3500 4-64

1 (M)
FOR STATE
HEALTH DEPT.

16394

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16393

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u> <u>23.1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. 3, Berlin</u>				d. STREET ADDRESS <u>R.F.D. 3, Berlin</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Charles Victor Dinges</u>			4. DATE OF DEATH <u>II 5 1966</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u>	8. DATE OF BIRTH <u>5-23-1915</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor R. Dinges</u>				14. MOTHER'S MAIDEN NAME <u>Anne Heighan</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-18-6460</u>		17. INFORMANT (<u>brother-in-law</u>) Address <u>Wallace S. Cropper, Jr. Bishopville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Clifford E. Schott</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>II-7-66</u>		
EXAMINER'S NAME (Type) <u>Clifford E. Schott, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting <u>II-7-66</u> Address (Street, city, town, or county) <u>Worcester Co.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>II-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		23d. LOCATION (City, town or county) (State) <u>Berlin Worcester Md.</u>		
24. FUNERAL DIRECTOR <u>Anna A. Eurbage Berlin, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>				
				25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>				

10383

10383

10383

Medical Examination Certificate of Health

1. Name of Patient: _____

2. Age: _____

3. Sex: _____

4. Date of Examination: _____

5. Place of Examination: _____

6. Name of Examiner: _____

7. Signature of Examiner: _____

8. Signature of Patient: _____

9. Signature of Witness: _____

10. Signature of Physician: _____

11. Signature of Surgeon: _____

12. Signature of Dentist: _____

13. Signature of Nurse: _____

14. Signature of Pharmacist: _____

15. Signature of Physician Assistant: _____

16. Signature of Medical Student: _____

17. Signature of Medical Resident: _____

18. Signature of Medical Fellow: _____

19. Signature of Medical Officer: _____

20. Signature of Medical Director: _____

21. Signature of Medical Board: _____

22. Signature of Medical Society: _____

23. Signature of Medical Association: _____

24. Signature of Medical Council: _____

25. Signature of Medical Commission: _____

26. Signature of Medical Department: _____

27. Signature of Medical Branch: _____

28. Signature of Medical Division: _____

29. Signature of Medical Section: _____

30. Signature of Medical Unit: _____

31. Signature of Medical Group: _____

32. Signature of Medical Team: _____

33. Signature of Medical Staff: _____

34. Signature of Medical Personnel: _____

35. Signature of Medical Services: _____

36. Signature of Medical Facilities: _____

37. Signature of Medical Equipment: _____

38. Signature of Medical Supplies: _____

39. Signature of Medical Materials: _____

40. Signature of Medical Instruments: _____

41. Signature of Medical Devices: _____

42. Signature of Medical Machines: _____

43. Signature of Medical Tools: _____

44. Signature of Medical Implements: _____

45. Signature of Medical Apparatus: _____

46. Signature of Medical Apparatus: _____

47. Signature of Medical Apparatus: _____

48. Signature of Medical Apparatus: _____

49. Signature of Medical Apparatus: _____

50. Signature of Medical Apparatus: _____

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16395

16394

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
c. LENGTH OF STAY IN 1b <u>6 months</u>		d. STREET ADDRESS <u>9 N. Phila Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 N. Philadelphia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Alvin Fletcher</u>		4. DATE OF DEATH <u>Nov 7 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/25/18</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. FINDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coffee Shop Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
11. BIRTHPLACE (State or foreign country) <u>ADA. OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DONALD FLETCHER</u>		14. MOTHER'S MAIDEN NAME <u>OPAL CLIPPENGER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>397-09-5088</u>	
17. INFORMANT <u>Ocean City Police</u>		Address <u>Ocean City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary occlusion acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD with coronary sclerosis</u> (c) <u>ASCVD with coronary sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F.J. Townsend, Jr</u>		22. DATE SIGNED <u>Nov 8, 1966</u>	
EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/10/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMORIAL</u>		23d. LOCATION (City, town or county) (State) <u>Berlin MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 14 1966</u>			

10000

10000

RECEIVED EXAMINING OFFICE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, address, and other details. The form is mostly blank with some faint markings.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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16396

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16395

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Angelina</u> Middle <u>Renee</u> Last <u>Hall</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1966</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26 1966</u>		9. AGE (In years last birthday) Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ft. Meigs Fla.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Laurence Hall</u>			14. MOTHER'S MAIDEN NAME <u>Rosie Robins</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Rosie Hall, RFD 1, Snow Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.2</u> DUE TO <u>Interstitial Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary infection of</u> DUE TO (c) <u>unknown etiology</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>David Rafat</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>11-26-66</u>			
EXAMINER'S NAME (Type) <u>DAVID RAFAT</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill Md.</u>			
24. FUNERAL DIRECTOR <u>Thomas F. Fennell, Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

10330

10330

MINOR AL EXHIBIT 3 CERTIFICATE OF DEATH

10330

[Faint, mostly illegible text from a certificate of death, including fields for name, date of birth, date of death, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1d Film G383 12/1/66 mh

16397

CERTIFICATE OF DEATH

16396

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill				c. LENGTH OF STAY IN 1b 23 1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 427 Covington St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle C. Last Holland				4. DATE OF DEATH Month November Day 20 Year 1966			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/03	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.		IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister				10b. KIND OF BUSINESS OR INDUSTRY Holiness Church		11. BIRTHPLACE (County & State, or foreign country) Worcester Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Mose Holland				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213225410		17. INFORMANT Mary Elizabeth Holland, Snow Hill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 7 days 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the Registrar) attended the deceased from 6/23/58 , 19, to 11/19/66 , that (I) (we) last saw the deceased alive on 11/19/66 , and that death occurred at 7 P M, from causes and on the date stated above.							
22a. SIGNATURE Ivory U. Sully, Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/21/66	
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD				22d. ADDRESS P. O. Box 126, Berlin, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Baptist		23d. LOCATION (City or Town) (County) (State) Worcester Co. Maryland	
24. FUNERAL DIRECTOR William F. Harris, Snow Hill, Md.				25a. REC'D BY REGISTRAR Nov 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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For the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16398 CERTIFICATE OF DEATH 16397

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 23.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 708 Cedar Street		d. STREET ADDRESS 708 Cedar Street	
3. NAME OF DECEASED (Type or print) CHARLES HAROLD LAMBERTSON		4. DATE OF DEATH Month Nov. Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1894
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automotive	
11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrison Lambertson		14. MOTHER'S MAIDEN NAME Florence Ardis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Jennie Lambertson, Maryland		Address Pocomoke City,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT HEART FAILURE. 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) BRONCHIOGENIC CARCINOMA. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 18 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL , 1966, to NOVEMBER 1966, that (I) (we) last saw the deceased alive on 11/30 1966, and that death occurred at 9:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE Neville A. Baron		22b. DATE SIGNED 12/1/66	
22c. PHYSICIAN'S NAME (Type) NEVILLE A. BARON		22d. ADDRESS Pocomoke, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-2-1966	
23c. NAME OF CEMETERY OR CREMATOR First Baptist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR DEC 5 1966	
ADDRESS Pocomoke City, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16399

CERTIFICATE OF DEATH

16398

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. Pocomoke City</u>		d. STREET ADDRESS <u>R.F.D. #2 Box 231 23-1</u>	
3. NAME OF DECEASED (Type or print) <u>Lula</u> First <u>Smith</u> Middle Last		4. DATE OF DEATH <u>Nov. 26</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1885</u> 81 yts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cudgar Purnell</u>		14. MOTHER'S MAIDEN NAME <u>Martha ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-0406</u>	
17. INFORMANT <u>Elmer Smith</u> Address <u>R.F.D. 2 Pocomoke, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CARDIO-RENAL VASC. DISEASE</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6-8 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>65</u> , to <u>11/26</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>66</u> , and that death occurred at <u>5:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Neville A. Baron</u> M.D.		22b. DATE SIGNED <u>11/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>		22d. ADDRESS <u>POCOMOKE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-3-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Love</u> Address <u>New Church, Va.</u>		25a. REC'D BY REGISTRAR <u>DEC 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16400					16399				
1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City c. LENGTH OF STAY IN 1b 52 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. 1					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City d. STREET ADDRESS R.F.D. 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MAGGIE ELLA TAYLOR			4. DATE OF DEATH November 9 1966		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 21, 1878 9. AGE (In years last birthday) 87 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY -- 11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frank Russell					14. MOTHER'S MAIDEN NAME Margaret Thorns				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Clarence J. Taylor, Pocomoke City, Md. Address R.F.D. 1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 33IX DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Months years years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 1950 to Nov. 9, 1966 , that (I) (we) last saw the deceased alive on Nov. 9, 1966 , and that death occurred at 3:00 PM , from the causes and on the date stated above.									
22a. SIGNATURE Charles W. Trader					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED Nov. 11, 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.,					22d. ADDRESS 302 Market St., Pocomoke City, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-11-1966		23c. NAME OF CEMETERY OR CREMATORY First Baptist			23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR NOV 14 1966		
					25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16401

16400

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bishopville rural</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bishopville rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>life</u>				d. STREET ADDRESS <u>231</u>			
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle <u>Williams</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1895</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>17</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>George Riley</u>				14. MOTHER'S MAIDEN NAME <u>Alice Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-12-3701</u>		17. INFORMANT <u>Mary Pastley</u> Address <u>Bishopville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocardial</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>50 Nov 17 66</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 4 66</u> to <u>Nov 17 66</u> that (I) (we) last saw the deceased alive on <u>Nov 4 66</u> and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford E. Schott</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Schott</u>				22d. ADDRESS <u>Berlin Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Showell Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Showell Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard T. Watson</u>				ADDRESS <u>Delbyville, Dela.</u>		25a. REC'D BY REGISTRAR <u>Nov 21 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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Dear Mr. [illegible] [illegible]

Enclosed [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]

Very respectfully,
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16401

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> <u>23.1</u>	
		d. STREET ADDRESS <u>Rt #1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>B</u> Last <u>Wise</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>B-31-1907</u> <u>59</u> yrs.
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Thornton</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>349-163918</u>	
17. INFORMANT <u>JACK Wise</u> Address <u>Rt #1 Snow Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA</u> 9369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SUBDURAL HEMATOMA</u> (c) <u>TRAUMA (EXTERNAL)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNDETERMINED</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ALCOHOL CONTENT OF BLOOD WAS, 0.25%</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>UNKNOWN</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>UNKNOWN</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>UNKNOWN</u> e.m. <u>UNKNOWN</u> p.m. <u>UNKNOWN</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>UNKNOWN</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>UNKNOWN</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> <u>11/1/66</u>			
ACTUAL SIGNATURE <u>Robert C. LaMar</u> M.D.		22. DATE SIGNED <u>11/1/66</u>	
EXAMINER'S NAME (Type) <u>ROBERT C. LAMAR MD.</u>		Address <u>Snow Hill, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-10-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baptist</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>	
24. FUNERAL DIRECTOR <u>Loretta B. Jolley - Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1966</u>	
ADDRESS <u>Rt #1</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1510

18803

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "TOWN" and "CITY" are faintly visible.]